Woodmont Center
Genesis HealthCare

11 Dairy Lane; PO Box 419
Fredericksburg, VA 22405-2663
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February 27, 2015

Wietshe G. Weigel-Delano, LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Henrico, Va. 23233-1485

Re: Allegation of Compliance for Plan of Correction of survey dated 2-5-15,
Woodmont Center SNF/NF 495246

Dear Mrs. Weigel-Delano:

Please find enclosed our facility's 2567 POC with Allegation of compliance for the above referenced survey.

I am requesting your acceptance of our 2567 POC dated February 5, 2015 containing our Allegation of Compliance dated March13, 2015 with the state and federal regulations for operation of long term care facilities. Please let me know if you need additional information.

Thank you for your assistance in this approval process.

Sincerely,

Karen S. Green
Administrator

enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	PO BOX 419 11 DAIRY LANE FREDERICKSBURG, VA 22404

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/3/15 through 2/5/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 118 certified bed facility was 102 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #18) and 5 closed record reviews (Residents #19 through #23).	F 000	This is our facility's Allegation of Compliance. Woodmont Center does not admit or deny the existence of the alleged deficiencies. Woodmont Center maintains that it is in substantial compliance and the Plan of Correction below will be completed by Karen S. Green 3 / 13 /2015 Karen S. Green Date Administrator RECEIVED MAR 02 2015 VDH/OLC	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and prepare food in a sanitary manner. 1. The reach in refrigerator was not in proper operating condition. The temperature of the reach-in refrigerator was not in the acceptable	F 371	F 371 SS=F On 2-4-15 dietary staff discontinued using the reach-in refrigerator. Dietary staff kept tray line cold food at desired temps with ice chest. Garnett Refrigeration checked the reach-in refrigerator and determined it was functioning according to the owner's manual from Traulsen & Co., Inc. 3/13/15 The reach- in refrigerator was placed facing away from the tray line and ovens on 2-24-15. The Maintenance Director reset the Standard Temp	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen S. Green — TITLE: Administrator — (X6) DATE: 2-27-2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 371	Continued From page 1 temperature range. 2. A dietary aid did not have facial hair (beard) restrained while assisting on the tray line at dinner time. The findings include: 1. The reach in refrigerator was in proper operating condition. The temperature of the reach-in refrigerator was not in the acceptable temperature range. On 2/3/15 at approximately 1:30 p.m. the reach in refrigerator was observed with the electronic temperature gauge reading "-def" (defrost). With the assistance of OSM (other staff member) # 2, the assistant dietary manager, the thermometer inside the refrigerator was observed - there was one on the floor of the refrigerator. The thermometer on the floor of the refrigerator read 68 degrees. The following food items were observed inside the reach in refrigerator: five ½ pint containers of whole milk, five ½ pint containers of reduced fat milk, one ½ pint container of chocolate milk, two ½ pint containers of fat free milk, one nutritional shake - strawberry flavor, three cups of strawberry yogurt, and a smoothie. The temperatures of a sampling of these items were obtained by OSM # 2 in the presence of two inspectors. OSM # 2 used a facility thermometer to obtain the temperatures. One of the yogurts had a temperature of 51.7 degrees, one of the containers of milk had a temperature of 52.8 degrees, and the smoothie was 48.3 degrees. All perishable food items in the refrigerator were discarded.	F 371	operation cycle to the Colder Temp operation cycle which lowered the operating pre-set from (36 degree F) range of 32-40 degrees F to pre-set (34 degree F) range of 25-35 degrees F. At the end of the tray line process all cold items left in the reach- in refrigerator were within their approved temps for storage and serving (ice cream 10 degrees F, applesauce 30 degrees F, and sandwiches 31 degrees F) The temperature on the inside thermometer was 39 degrees F of the reach-in at the end of tray line. The Colder Temp operation cycle maintained the reach-in's inside temperatures below 38 degrees F during the tray line process. Food is pre- chilled in the refrigerators with doors closed at least one hour before tray line begins. Frozen food is taken from the freezer and placed in the bottom of the reach-in refrigerator at the beginning of the tray line process. Dietary staff have been in-serviced on monitoring the reach-in refrigerator temps before each tray line process at each meal and at the end of each meal	3/13/15 3/13/15

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On 2/4/15 at 4:45 p.m. the reach-in refrigerator was again observed with the electronic temperature gauge reading "-def" (defrost). With the help of OSM # 2 the thermometers inside the refrigerator were observed - there were two, one at the back top and one on the floor of the refrigerator. The thermometer on the floor of the refrigerator read 58 degrees and the one from the top back read 50 degrees. Food items were observed inside the reach-in refrigerator. OSM # 2 was asked to check the temperatures of these items and using a facility thermometer and in the presence of two inspectors OSM # 2 obtained the following temperatures. These included a vanilla frozen treat, identified as non-dairy that was squishy, and pudding identified as canned shelf stable had a temperature of 51 degrees. All items in the refrigerator were placed in bins with ice.

During an interview on 2/4/15 at 5:05 p.m. with OSM # 4, the cook, OSM # 4 was asked about checking the temperatures on the reach-in refrigerator. OSM #4 stated the staff check the temperature on the outside. It doesn't always read defrost, if it does then they check the thermometer inside. OSM # 4 further stated that the temperatures are taken by the cook that starts the day and also at the end of the day. ASM # 2, the assistant dietary manager, provided the temperature logs. These logs documented that temperatures were taken two times per day just as OSM # 4 stated.

On 2/4/15 at 6:35 p.m. with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nurses, this concern was revealed.

served. If the temps fall out of the approved standard range for cold food items being served as listed on the posted temp recording log (32-40 degrees F) on the refrigerator, the cook - supervisor will discontinue the refrigerator's usage and put the cold tray line items in Dietary's ice chest as a backup. The cook-supervisor will notify the facility Maintenance Director, FSM, and Administrator immediately concerning the faulty reach-in refrigerator for correction of the appliance. 3/13/15

The reach-in refrigerator logs will be reviewed monthly at the facility QA meeting for compliance. 3/13/15

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A copy of the facility policy for temperatures and the manufacture's information on the reach in refrigerator was requested.

During an interview on 2/5/15 at 9:55 a.m. with ASM # 1 any facility policy for the reach in refrigerator was again requested. During this interview ASM # 1 revealed that she had the maintenance department remove the reach in refrigerator from service after the end of day interview on 2/4/15.

Review of the facility policy: "Refrigeration/Freezer Temperature Standards" revealed the following: Under "Policy: Refrigerators and freezers operated within acceptable temperature range." "Purpose: To ensure food held in refrigerated equipment is maintained at a safe temperature." "Process: 3. If temperatures fall outside the acceptable range, the Maintenance Department is notified immediately. 3.1 If repair is delayed, consideration must be made regarding the relocation of perishable items. 4. Acceptable ranges are: 4.1 Refrigerators 32 degrees -- 40 degrees Fahrenheit. 4.2 Freezers -10 degrees - 0 degrees Fahrenheit."

Review of the owner's manual for the "Air-Curtain Refrigerator" used in the kitchen documented the following: "The Air Curtain Refrigerator is specifically designed to hold 45 degrees F or lower temperature with the door(s) open for a minimum of 30 minutes, or longer dependent upon application and operating conditions (room temp, humidity, surrounding air exchanges, and voltage). When the door of the unit is closed, it operates as a force air refrigerator with a highly efficient refrigeration system that provides faster

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F 371	Continued From page 4 'pull down' and 'recovery' times than standard refrigerators. When the door is opened, a series of blower fans create a 'wall' of air and areas of pressure, localizing a unique pattern of air from both the left and right side walls, as well as from the top. This movement across the cabinet opening keeps the cold air in and the warm air out of the food zone for prolonged periods of time..." No further information was provided by the end of the survey. 2. A dietary aid did not have facial hair (beard) restrained while assisting on the tray line at dinner time. During an observation on 2/4/15 at approximately 5:10 p.m. OSM (other staff member) # 3, a dietary aide, was observed helping on the tray line. OSM # 3 did not have a beard restraint covering his beard; the beard was at least one inch long at the chin. OSM # 3 was observed taking plates that had food on them from the cook and placing the plates onto resident food trays, then placing a dome lid over the food. During an interview on 2/4/15 at 6:10 p.m. with OSM # 2, the assistant dietary manager, the observation of OSM # 3 without a beard restraint was revealed. OSM # 2 was asked if dietary staff is supposed to have their hair including beards covered. OSM # 2 responded, "Yes." On 2/4/15 at 6:35 p.m. with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nurses, this concern was revealed. A copy of the facility policy for restraint of hair in the dietary department was requested.	F 371	All dietary staff with facial beards have been in-serviced and supplied with beard restraining nets. Any bearded Dietary staff working in the department without their beard hair net will be counseled by their supervisor and excused from the department until they are wearing their beard net while on duty. Their supervisor will immediately report any staff member on duty not wearing their beard net to the FSM and facility Administrator. The employee will be placed in a Performance Improvement plan by their supervisor for immediate correction of their failure to wear a net covering over their facial hair while on duty in dietary department.	3/13/15 3/13/15

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F 371	Continued From page 5 During an interview on 2/5/15 at 9:55 a.m. with ASM # 1 any facility policy for the restraint of hair and beards was again requested. An interview on 2/5/15 at 10:25 a.m. with ASM # 1 revealed that OSM # 3 now has a net on his beard from that point forward. On 2/5/15 at 10:30 a.m. OSM # 6, the registered dietitian, provided the facility policy "Personal Hygiene." The policy "Personal Hygiene" was reviewed and the following was documented: Under "PROCESS" "7. Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover all facial hair." No further information was provided by the end of the survey.	F 371	The Administrator will report during the monthly QA meeting the status of dietary employees that have been presented with Performance Improvement plans for their immediate compliance with the facility's beard restraining nets policy while working in dietary for monitoring.	3/13/15
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain the dumpster in an area free of debris. The findings include:	F 372	F 372 SS=F The Maintenance Director and a Housekeeping Floor Tech cleaned the exterior of the building, parking lot, surrounding grounds, patios, ashtrays, sidewalks, and dumpster and loading dock areas of debris and discarded the trash in the dumpster on 2-5-15.	3/13/15

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F 372	Continued From page 6 During an observation on 2/3/15 at approximately 1:30 p.m. of the dumpster area with OSM (other staff member) # 2, the assistant dietary manager, and in the presence of two state inspectors the following was observed: There was food on the side of the dumpster and on the ground (looked like creamed corn); on the ground around the dumpster were eight plus plastic gloves, plastic silverware - knives and spoons, two Ziploc bags, one plastic plate, one aluminum soda can, one plastic clothes hanger, multiple empty plastic single-serve coffee creamers, one white towel, one white rag, one plastic and metal dispenser pump, a plastic green wrapper, multiple plastic condiment cups, multiple plastic drink lids, and several straws. During an interview on 2/3/15 at approximately 1:40 p.m. with OSM # 2, OSM # 2 was asked who was responsible for keeping the dumpster area clean. OSM # 2 stated that he did not know who was responsible; OSM # 2 stated, "Everybody in the building comes out and uses the dumpster." An observation was made on 2/4/15 at 7:50 a.m. of the dumpster and the area around the dumpster and there was no change. On 2/4/15 at 6:35 p.m. during an interview with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nurses, this concern was revealed. A copy of the facility policy for maintaining the dumpster area was requested. During an interview on 2/5/15 at 9:55 a.m. with ASM # 1 any facility policy for the dumpster area was again requested. When ASM # 1 was asked how often the dumpster area is cleaned. ASM #	F 372	The Environmental Services Director in-serviced their department on the facility's "Outside Cleaning Policy" and the assigning of Environmental Staff to make two rounds each day and keep clear facility grounds, entrances, exits, sidewalks, parking lot, courtyards, dumpster areas, ashtrays, of debris and trash and discard trash in the dumpster. The Environmental Services Director/Designee will walk the areas at the beginning and ending of their shift to check for the department's compliance in keeping all assigned areas clean. If the ESD finds any irregularities in compliance with the cleaning of outside areas they will assign the ES staff to clean the outside areas until they are compliant with the facility's cleaning policy before leaving for the day. The facility Administrator/Designee will make random daily checks of these areas and record findings on a cleaning check log for compliance with facility "Outside Cleaning	3/13/15 3/13/15 3/13/15

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F 372	Continued From page 7 1 stated that the area is supposed to be checked two times a day, but at least once. During an interview on 2/5/15 at 11:28 a.m. with ASM # 1, the administrator, and ASM # 2 this finding was again reviewed. Review of the facility policy "Outside Cleaning" "POLICY: The exterior of the building and surrounding grounds are policed for cleanliness and overall appearance. PURPOSE: To ensure the exterior of the building and surrounding grounds are clean and free of debris. PROCESS: 1. The Environmental Services Director assigns housekeeping employees to police and clean the outside areas. 2. Areas include all entrances, exits, sidewalks, driveways, parking lot, dumpster, loading dock, patios, and courtyards. 3. Maintenance of these areas include removal of trash, emptying of ashtrays, sweeping of sidewalks, picking up debris, and straightening and cleaning of outdoor furnishings. 4. Discard trash in dumpster." No further information was provided prior to exit.	F 372	Policy". The Administrator/Designee will report the facility's compliance with the "Outside Cleaning policy" during the monthly QA meeting for monitoring.	3/13/15
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to obtain	F 502 SS-D	1) On 2-5-15 Resident #13 had physician ordered labs drawn by lab tech. The results showed that Resident #13 suffered no ill effects by not drawing the labs in January, 2015. 2) Resident #15 had physician ordered labs drawn by lab tech on 2-10-15. The results showed that Resident #15 suffered no ill effects by not drawing the labs in November 2014.	3/13/15

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physician ordered labs (laboratory tests) for 2 of 23 residents in the survey sample; Residents #13 and #15.

1. For Resident #13, the physician wrote an order on 8/14/14 for a CBC, CMP, and an HgA1C to be drawn every 6 months, in January and July. As of the survey (2/3/15 to 2/5/15) the January 2015 lab draw was not obtained.

2. For Resident #15 the facility staff failed to obtain laboratory tests that were to be drawn in November 2014.

The findings include:

1. Resident #13 was admitted to the facility on 12/19/12 with the diagnoses of but not limited to diabetes, high blood pressure, above knee amputation, coronary artery disease, and peripheral vascular disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/9/15. The resident was coded as requiring total care for transfers, dressing, hygiene, and bathing; independent for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the January 2015 POS (Physician's Order Sheet), and was signed by the physician on 1/22/15. This POS contained an order dated 8/14/14 for a CBC (complete blood count *), CMP (comprehensive metabolic panel **), and an HgA1C (hemoglobin A1C test to measure blood sugar ***) to be drawn every 6 months, in January and July. Further review revealed there were no lab results for January 2015 in the clinical record for the above

Facility licensed nurses were in-serviced on the importance of obtaining labs per physician orders. 3/13/15

Facility ADONs audited all active resident charts by 2-19-15 and found no other residents were affected by this deficient practice. 3/13/15

ADONs will perform weekly lab audits to monitor compliance of labs drawn with physician orders. Any irregularities found will be corrected immediately by facility ADONs. 3/13/15

All lab audit results will be reported during monthly QA meetings for monitoring. 3/13/15

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identified labs.

On 2/4/15 at approximately 1:20 p.m., LPN #1 (Licensed Practical Nurse) was asked about the lab results. At approximately 1:30 p.m., LPN #1 stated the labs were not done and she would look into it.

On 2/4/15 at approximately 2:53 p.m., LPN #1 stated the process for labs (laboratory tests) was the nurse was to transcribe the order into the computer directly to the lab company electronic system, obtain a confirmation number and write it on the order. Then the order was to be transcribed onto the MAR/TAR (Medication Administration Record / Treatment Administration Record) and added to the lab log for tracking the orders to be done. She stated it appeared that the order was never taken off as there was no evidence of a confirmation number.

A review of the care plan revealed the following care plans in part:
"..at risk for cardiovascular symptoms or complications..., The resident has a diagnosis of diabetes..., ...exhibits or is at risk for gastrointestinal symptoms or complications..., and...nutritional risk: h/o (history of) sig (significant) wt (weight) loss and skin breakdown..." All of the above were most recently revised on 1/21/15; and all contained an intervention for obtaining labs as ordered and reporting results to the physician (the intervention date was 12/21/12 for each one except the nutritional care plan, for which the intervention was dated 12/26/12.)

A review of the facility policy, "Diagnostic Tests" documented, "Policy: Diagnostic tests - including

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laboratory, radiologic, pulmonary, and waived testing (e.g., fingerstick glucose monitoring, hemoccult testing) - will be performed as ordered. Laboratory services will be available on-site, seven days a week, 24 hours a day with a licensed outside diagnostic service that meets all applicable certification standards and local or state regulations. All diagnostic results are reported to attending physician/mid-level provider promptly.....Practice Standards: 1. Verify order for laboratory, diagnostic testing, and parameters for reporting. 2. Notify diagnostic service to arrange for test. 2.1 Arrange transportation if patient needs to leave the Center for specialized diagnostic tests. 3. Obtain report of diagnostic test. 4. Notify physician/mid-level provider of diagnostic test results. 4.1 Notify immediately of any critical values. 4.2 Notify per ordered parameters. 5. Document date and time of physician/mid-level provider notification and response in the medical record."

On 2/5/15 at 11:25 a.m., the Administrator and Director of Nursing were made aware of the findings. No additional information was provided by the end of the survey.

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment." And on page 236, "As an instrument of continuous client care and as a legal document, the client record should contain all

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pertinent assessments, planning, interventions, and evaluations for that client."

*According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques.

**A comprehensive metabolic panel is a group of chemical tests performed on the blood serum (the part of blood that doesn't contain cells). These tests include total cholesterol, total protein, and various electrolytes. Electrolytes in the body include sodium, potassium, chlorine, and many others. The rest of the tests measure chemicals that reflect liver and kidney function. This test helps provide information about your body's metabolism. It gives your doctor information about how your kidneys and liver are working, and can be used to evaluate blood sugar, cholesterol, and calcium levels, among other things. This information was obtained from the website: <http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm>

**HgA1C is a test that measures the amount of glycated hemoglobin in your blood. It is used to measure your blood sugar control over several months. It can give a good estimate of how well you have managed your diabetes over the last 2 or 3 months. Website accessed: http://www.nlm.nih.gov/medlineplus/ency/article/003640.htm

2. For Resident #15 the facility staff failed to

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obtain laboratory tests that were to be drawn in November 2014.

Resident # 15 was admitted to the facility on 3/3/11 and readmitted on 8/16/11 with diagnoses that included but were not limited to: diabetes, high blood pressure (HTN), depression, hypothyroidism, congestive heart failure (CHF), diverticulosis, hiatal hernia, and hypothyroidism.

Resident # 15's most recent MDS (minimum data set) was a quarterly assessment, with an ARD (assessment reference date) of 11/10/14. The Resident was coded as being usually understood by others and as usually understanding others. The resident was cognitively intact, scoring a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

During a review of the clinical record a physician order dated 10/24/12 and signed by the physician on 1/14/15, documented, "CBC, CMP, MG every 6 months (May-Nov)." (CBC - complete blood count; CMP - complete metabolic panel; MG - magnesium level)

Review of the clinical record did not reveal the results of these laboratory tests for the month of November 2014.

The comprehensive care plan dated, 3/7/11 and recently revised on 11/17/14, documented, "Focus: Resident exhibits or is at risk for cardiovascular symptoms or complications related to HTN, CAD (coronary artery disease), CHF..." Under the column, "Interventions" "Obtain labs/EKG as ordered and report to MD as indicated."

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During an interview on 2/4/15 at 2:30 p.m. with RN (registered nurse) # 3, RN # 4, and RN # 5 the process for obtaining a lab (laboratory test) was reviewed. All three RNs concurred that the process is as follows: review the order whether written or by telephone, and transcribe the order into the lab log in the computer. The 11-7 shift staff prints the lab log for the upcoming day. Staff also needs to make sure that the Resident is still in the facility and then double checks the order. After this review is done the lab log is put into the lab book for the lab tech. The lab requisition goes behind the lab log and the lab tech puts the specimen with the lab requisition and initials the lab log indicating that the lab specimen has been collected. If the resident refuses the lab or the lab tech cannot obtain the specimen this is noted on the lab log and the lab tech is to notify the nurse as well. It depends on the lab test as to when they get the results but usually the lab faxes the results and the 3-11 supervisor/staff receives the report and reconciles the test with the lab log. The physician is notified either in person or via telephone call. There is a notation on the lab report if there is a new order or not. If a new order then the process starts over.

During an interview on 2/5/15 at 9:20 a.m. with OSM (other staff member) #1, director of medical records, the process for filing laboratory reports was reviewed. OSM #1 stated, "The filing is done by the nurses or supervisors. I just thinned resident records last Friday and perhaps the lab is in that stack."

During an interview on 2/5/15 at 9:35 a.m. with OSM (other staff member) #1, director of medical records, a request was made for the lab in the thinned record. OSM # 1 reviewed the thinned

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record with this inspector and agreed that the laboratory finding was not in the thinned clinical record.

During an interview on 2/5/15 at 9:38 a.m. with ASM (administrative staff member) # 2, the director of nurses, the missing laboratory report for November 2014 was revealed. ASM # 2 stated that she would go on the lab web site and see if the lab was done and if so get a copy of the report.

An interview on 2/5/15 at 9:50 a.m. with ASM # 2 revealed that when she accessed the lab web site she could find no proof that the lab was drawn.

During an interview on 2/5/15 at 11:28 a.m. with ASM # 1, the administrator, and ASM # 2 this finding was reviewed.

No further information was provided by the end of the survey.

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007. Page 165, Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419, "The physician is responsible for directing medical treatment. Nurses are

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obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

Reference:

(1) A complete blood count (CBC) test measures the following: The number of red blood cells (RBC count) the number of white blood cells (WBC count).
<http://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&query=CBC&x=24&y=17>

(2) The complete metabolic panel (CMP) is a group of blood tests that provides information about your body's metabolism
<http://www.nlm.nih.gov/medlineplus/ency/article/002257.htm>

(3) This test, magnesium (MG) is done when your health care provider suspects you may have an abnormal level of magnesium in your blood.
www.nlm.nih.gov/medlineplus/ency/article/003487.htm

F 504 SS=D 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was

F 502

F 504

F 504
SS-D
Resident #6 physician determined that the resident experienced no ill effects from the lab tests. 3/13/15

Licensed nurses were in-serviced by the Nurse Practice Educator RN in February concerning the importance of obtaining a physician order prior to the lab draw. 3/13/15

Facility ADONs audited all active resident charts and found no other 3/13/15

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F 504	Continued From page 16 determined that the facility staff failed to obtain a physician order prior to performing a laboratory tests for one of 23 residents in the survey sample, Resident # 6. For Resident #6, the facility staff failed to obtain a physician's order prior to performing a *CBC (complete blood count) and *CMP (complete metabolic panel) on 9/22/14 and 10/6/14. The findings include: Resident # 6 was admitted to the facility on 9/2/14 with diagnoses including, but not limited to: anemia, depression, hypertension, hiatal hernia, hyperlipidemia, and hip fracture. Resident # 6's most recent MDS (minimum data set) was a significant change assessment, with an ARD (assessment reference date) of 12/8/14. The Resident was coded as being usually understood by others and as usually understanding others. The resident was cognitively intact, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of Resident # 6's clinical record revealed results from a CBC and CMP on 9/22/14 and 10/6/14. Further review of Resident # 6's clinical record revealed no evidence of a physician's order for the above-referenced laboratory tests. During an interview on 2/4/15 at 12:50 p.m. with OSM (other staff member) #1, director of medical records, a request for Resident # 6's thinned record was made. The thinned record was	F 504	residents that were affected by the deficient practice. ADONs will perform weekly lab audits to monitor compliance that labs are only being drawn with physician orders. Any irregularities found will be corrected immediately by facility ADONs. All lab audit results will be reported during monthly QA meetings for monitoring.	3/13/15 3/13/15 3/13/15

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reviewed and no order could be located for the above mentioned laboratory tests. OSM # 1 stated that she had just thinned the clinical records and would look for the order in that stack.

During an interview on 2/4/15 at 2:00 p.m. with OSM (other staff member) #1, director of medical records, OSM # 1 revealed that she (OSM # 1) could not find an order for the laboratory tests.

During an interview on 2/4/15 at 2:30 p.m. with RN (registered nurse) # 3, RN # 4, and RN # 5, the process for obtaining a lab was reviewed. All three RNs concurred that the process is as follows: review the order whether written or by telephone, and transcribe the order into the lab log in the computer. The 11-7 shift staff prints the lab log for the upcoming day. Staff also needs to make sure that the Resident is still in the facility and then double checks the order. After this review is done the lab log is put into the lab book for the lab tech. The lab requisition goes behind the lab log and the lab tech puts the specimen with the lab requisition and initials the lab log indicating that the lab specimen has been collected. If the resident refuses the lab or the lab tech cannot obtain the specimen this is noted on the lab log and the lab tech is to notify the nurse as well. It depends on the lab test as to when they get the results but usually the lab faxes the results and the 3-11 supervisor/staff receives the report and reconciles the test with the lab log. The physician is notified either in person or via telephone call. There is a notation on the lab report if there is a new order or not. If a new order then the process starts over.

On 2/4/15 at 6:35 p.m. during an interview with ASM (administrative staff member) #1, the

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administrator, and ASM #2, the director of nurses, this concern was revealed. A copy of the facility policy for obtaining laboratory tests was requested.

During an interview on 2/5/15 at 11:28 a.m. with ASM # 1, the administrator, and ASM # 2 this finding was again reviewed.

A review of the facility policy entitled "Diagnostic Tests" revealed, in part, the following: "Verify order for laboratory, diagnostic testing, and parameters for reporting."

No further information was provided prior to exit.

Reference:

*A complete blood count (CBC) test measures the following:
The number of red blood cells, white blood cells, the total amount of hemoglobin, and the fraction of the blood composed of red blood cells.
The CBC test also provides information about the following measurements:
Average red blood cell size (MCV)
Hemoglobin amount per red blood cell (MCH)
The amount of hemoglobin relative to the size of the cell (hemoglobin concentration) per red blood cell (MCHC)
The platelet count is also usually included in the CBC.
http://www.nlm.nih.gov/medlineplus/ency/article/003642.htm

*The complete metabolic (CMP) panel is a blood test used to evaluate the kidneys, liver, blood sugar, protein, electrolytes and acid/base balance. This information was obtained from the

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website:
http://www.nlm.nih.gov/medlineplus/ency/article/003468.htm

F 514 SS=D 483.75(l)(1) RES
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 23 residents in the survey sample; Residents #1 and #15.

1. Resident #1's clinical record contained a document with another resident's name.

2. Resident #15's clinical record contained a document with another resident's name.

The findings include:

F 504

F 514
SS=D

1) Resident #1's medical record was corrected immediately by the DON by removing the incorrect lab from Resident #1's record. 3/13/15

2) Resident #15's clinical record was corrected immediately by the LPN by refiling the lab in the correct resident's medical chart. 3/13/15

Licensed nurses were in-serviced on the importance of filing lab results in the correct resident's medical record. 3/13/15

ADONs audited active resident medical charts and found no other resident charts were effective by the deficient practice. 3/13/15

ADONs will perform weekly resident chart audits to determine that labs are filed in the correct medical record. 3/13/15

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F 514	Continued From page 20	F 514	All lab audit results will be reviewed at the monthly QA meeting for monitoring that all labs are filed in the correct resident's chart.	3/13/15

1. Resident #1 was admitted on 10/13/14 with diagnoses of but not limited to: urinary tract infection, constipation, renal mass, hematuria, gastroesophageal reflux disease, macular degeneration, arthritis, falls, atelectasis bronchectasis, neutropenia, thromboeytopenia and Methicillin-resistant Staphylococcus Aureus (MRSA).

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/8/14 coded Resident #1 as being severely impaired of cognition for daily decisions. Resident #1 was coded as being totally dependent of one staff member for ADLs (activities of daily living).

On 2/4/15 at approximately 3:00 p.m. Resident #1's clinical record was reviewed in the presence of the DON (director of nursing). Resident #1's clinical record revealed laboratory test results from (Name of Laboratory) dated 1/24/15 for another resident. When asked if the laboratory test results dated 1/24/15 for another resident were filed in the correct clinical record the DON stated, "No. This was misfiled."

On 2/5/15 at approximately 9:15 a.m., an interview was conducted with OSM (other staff member) #1, director of medical records. When asked what the procedure was for filing laboratory test results in the resident's clinical record, OSM #1 stated, "The filing is done by the nurses or supervisors. Anyone who is working in a chart and finds information that does not belong in the record should take it out and file it in the correct record."

On 2/5/15 at approximately 9:25 a.m., an

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interview was conducted with the DON, regarding the procedure for filing laboratory test results in the resident's clinical record. The DON stated, "When the lab (laboratory) results come back, the supervisors place the lab results in the resident's chart and flag them until the doctor reviews and signs them. Then the labs are filed in the resident's chart."

The facility's policy, "Clinical Record: Charting and Documentation" documented, "Only authorized personnel or individuals may provide documentation in the clinical record that shall include the medical plan of treatment, assessments, interventions, responses to care and treatment by multiple health care providers, or identification of significant changes, accidents, or unusual occurrences, that may impact the patient's physical or emotional well being and the plans for the patient at discharge."

The Administrator and DON were made aware of these findings on 2/4/15 at approximately 6:35 p.m.

No further information was provided by the end of the survey.

2. Resident #15's clinical record contained a document with another resident's name.

Resident # 15 was admitted to the facility on 3/3/11 and readmitted on 8/16/11 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, hypothyroidism, congestive heart failure, diverticulosis, hiatal hernia, and hypothyroidism.

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Resident # 15's most recent MDS (minimum data set) was a quarterly assessment, with an ARD (assessment reference date) of 11/10/14. The Resident was coded as being usually understood by others and as usually understanding others. The resident was cognitively intact, scoring a 12 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

During a clinical record review another resident's laboratory report was observed in Resident # 15's record.

During an interview on 2/5/15 at 9:15 a.m. with LPN (licensed practical nurse) # 2 this finding was confirmed. When LPN # 2 was asked who does the filing of laboratory reports, LPN # 2 stated that it varies.

During an interview on 2/5/15 at 9:20 a.m. with OSM (other staff member) #1, director of medical records the process for filing laboratory reports was reviewed. OSM #1 stated, "The filing is done by the nurses or supervisors. Anyone who is working in a chart and finds information that does not belong in the record should take it out and file it in the correct record."

An interview on 2/5/15 at 9:25 a.m. with ASM (administrative staff member) # 2, the director of nurses, was asked what the procedure for filing laboratory reports. ASM # 2 stated, "When the lab results come back the supervisors place the lab results in the resident's chart and flag them until the doctor reviews and signs them. Then the labs are filed in the resident's chart." During this interview the misfiled laboratory report was revealed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23	F 514		

The facility's policy, "Clinical Record: Charting and Documentation" documented, "Only authorized personnel or individuals may provide documentation in the clinical record that shall include the medical plan of treatment, assessments, interventions, responses to care and treatment by multiple health care providers, or identification of significant changes, accidents, or unusual occurrences, that may impact the patient's physical or emotional well being and the plans for the patient at discharge."

During an interview on 2/5/15 at 11:28 a.m. with ASM # 1, the administrator, and ASM # 2 this finding was reviewed.

No further information was provided by the end of the survey.

Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of

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	495246	A. BUILDING _____ B. WING _____	02/05/2015

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F 514	Continued From page 24 documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."	F 514		

State of Virginia

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure survey was conducted 2/3/15 through 2/5/15. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 118 certified bed facility was 102 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #18) and 5 closed record reviews (Residents #19 through #23).

F 001	Non Compliance	F 001	F 001	

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12VAC5-371-140. Policies and procedures
Cross reference to F502

12VAC5-371-310. Diagnostic services
Cross reference to F502

Based on staff interview, facility document review, and review employee record review, it was determined the facility staff failed to obtain reference verification for 1 of 20 employee records reviewed (new hires for the last 2 years); Other Staff Member #8 (OSM), Activities.

12VAC5-371-110. Management and administration.
B. The nursing facility must comply with:
1. These regulations (12VAC5-371);
2. Other applicable federal, state or local laws and

F 001

OSM #7 obtained 2 previous job references by phone for OSM #8's facility employee record. OSM #7 reported the GIS system's failure to record the employee's 2 pre-hire previous job references to our Corporate Regional HR Manager. 3/13/15

The Administrator in-serviced OSM #7 on the facility's pre-hire employment policy of 2 previous employer references to be obtained prior to hire and remain in the employees completed personnel file. 3/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of Virginia

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F 001	Continued From Page 1	F 001		

regulations; and
3. Its own policies and procedures.

12VAC5-371-140. Policies and procedures.
E. Personnel policies and procedures shall include, but are not limited to:
3. An accurate and complete personnel record for each employee including:
a. Verification of current professional license, registration, or certificate or completion of a required approved training course;
b. Criminal record check.

Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check."

On 2/5/15 a review of 20 employee records was conducted for new hires for the last 2 years. References were not available in the employee record for OSM #8.

On 2/5/15 at approximately 10:00 a.m., OSM #7 (HR/Payroll) was made aware of the missing references. She stated they could not be located. (On 2/4/15 at approximately 4:00 p.m., she had stated that portions of the employee records, including references, were being sent from the home office in Pennsylvania, due to the corporation not allowing certain parts of the records to be kept onsite).

A review of the facility policy, "Outline of New Employee Screening and Training" documented, "C. We contact past and present employers by

If when the OSM #7 receives the GIS pre-hire reference and background report from corporate the 2 previous employer reference checks are not included OSM #7 will obtain the references over the phone prior to hire. 3/13/15

The facility Administrator will review all pre-hire employment records before the applicate is hired for compliance with and 12VAC5-371-110 Management and administration and 12VAC5-371-140 Policies and Procedures Personnel. 3/13/15

The facility Administrator will report to the monthly QA meeting the effectiveness of this plan of correction for monitoring. 3/13/15

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F 001	Continued From Page 2	F 001		

phone or by fax to ask them about the applicants work performances. We also accept letters of reference."

On 2/5/15 at 11:25 a.m., the Administrator and Director of Nursing were made aware of the findings. No additional information was provided by the end of the survey.

The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:

12VAC5-371-310. Diagnostic services. A. Cross reference to F 502 and 504

12 VAC 5-340 & 12 VAC 5-421-1770 -- A, B Cross Reference to F-371

12 VAC 5-317-360 E Clinical Records- Cross Reference to F 514

12VAC5-371-360A Cross Reference to F514